

## TRANSACTIONS OF THE NEW YORK SURGICAL SOCIETY.

*Stated Meeting, May 9, 1894.*

The President, ROBERT ABBE, M.D., in the Chair.

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### LEONTIASIS OSSEA.

DR. CHAS. T. PARKER presented a patient, a man, thirty-eight years of age, who came to the Chambers Street Hospital, April 24, 1894, complaining of lancinating headache, impairment of hearing and of memory, drowsiness, despondency, and at times of suicidal impulse. General history negative.

About fourteen years ago the patient received a blow on the top of the head, producing a fracture of the skull. Seven years ago he noticed a small lump near the angle of the left inferior maxilla, which went on to increase slowly until his appearance at the hospital. Five years ago a growth of similar character began under the left eye, and was followed by one under the right eye and another at the angle of the right inferior maxilla and beneath the parotid gland. The nasal passages were nearly occluded.

The headache, of which the patient complained, was confined mainly to the frontal and left temporal regions.

DR. PARKER stated that the bone was solid throughout, as shown by drilling into it. The enlargements were limited to the bones of the head. The special sense and cerebral symptoms were supposed to be due to growth of bone within the cranium. The orbital fossæ and teeth were still in place, but the growth could be felt behind the hard palate and had nearly occluded the nasal fossæ.

### CHOLECYSTECTOMY; IMPACTED GALL-STONE IN THE COMMON BILE-DUCT.

DR. CHARLES K. BRIDGON presented a patient and read notes of the case taken by Dr. Forbes Hawkes, as follows: The patient, a

woman, thirty-four years of age, subject to constipation, was admitted to the Presbyterian Hospital on December 27, 1893, with a history of repeated attacks of biliary colic during the preceding five weeks. She was jaundiced, and a dilated gall-bladder could be imperfectly made out.

As the attack seemed to be on the wane when the patient presented herself, it was not considered advisable to undertake operative treatment at that time. She was kept in the hospital, her symptoms gradually subsiding with the tumor until January 22, when she was discharged.

On March 12, 1894, she returned, saying that five days before the old trouble had come back,—the pain in the right side, the chills, the fever and sweating, the constipated and light-colored stools. After a while the jaundice had also reappeared and had been increasing. When seen, the tumor in the right hypochondriac region could be plainly made out, her skin was deeply jaundiced, her dejecta very light-colored, and she complained of much pain over the tumor radiating upward.

DR. BRIDDON then operated, making a "Courvoisiers" incision about ten inches long, running obliquely parallel to the lower border of the ribs on the right side and about one-half inch below them, its centre over the most prominent part of the tumor.

After the peritoneal cavity had been laid open, on inspection no gall-bladder or resembling structure could be seen. In the position of the normal gall-bladder, however, a mass could be indistinctly made out by the examining finger, lying directly under the liver, composed apparently solely of omentum and adherent structures.

On careful blunt dissection with the finger this mass defined itself more clearly. Several rather firm adhesions were separated from it, and an adherent process of omentum, which was seen to run directly into the mass, was ligated off. The mass then showed itself to be the gall-bladder itself, its walls much thickened, the organ itself contracted. The process of the omentum, after reaching out for the inflamed gall-bladder, had evidently wrapped itself around it snugly on all sides and contracted firm adhesions to it throughout.

During the manipulations necessary to its liberation the gall-bladder was opened, liberating twelve to eighteen brown-colored, smooth, faceted stones, varying in size from the head of a pin to that of small dice, but no bile escaped.

After carefully freeing the gall-bladder on all sides from its sur-

rounding adhesions, it was cut off at its termination in the cystic duct below and removed. In doing so several bleeding vessels in the lower part of the wound were clamped. The clamps were left on for forty-eight hours, the mouths of the vessels being at too great a depth in the wound to be tied with safety.

The exploring finger passed down into the wound and along the common bile-duct failed to reveal the presence of any stone.

A probe introduced into the cystic duct failed to pass through the common duct into the intestine.

A drainage-tube of fair size, surrounded by iodoform gauze, was then introduced to the very bottom of the wound over the orifice of the cystic duct and kept in position by means of iodoform gauze packed around it.

Several silkworm-gut sutures were then taken in the two angles of the wound, limiting its extent somewhat, a copious aseptic dressing applied, and the patient returned to the ward.

She recovered well from the operation.

For the first few days the bile flowed out through the tube at the rate of approximately eight to ten fluid ounces a day, then steadily decreased. By the third day after the operation her jaundice was markedly less. Her fæces began to regain a more normal color though still somewhat constipated. The edges of the wound that had been brought together healed *per primam*. The wound itself was protected from the biliary discharge by rubber tissue. Her general condition improved immediately after the operation, the chills, fever, sweating, headache, and malaise ceased, and the patient made an uninterrupted recovery. Two weeks ago the discharge of bile from the wound had ceased entirely.

#### DOUBLE CHARCOT'S DISEASE OF THE HIP IN LOCOMOTOR ATAXIA.

DR. W. B. COLEY presented a man, a physician, forty-eight years of age, who first noticed, ten years ago, some trouble over the spine,—some pain, irritation on lying down, some change in sensation. Six years ago he noticed some disturbance in gait. When he closed his eyes he was unable to walk as well as when they were open. A year ago last November he fell from his carriage and injured his right hip. A few days afterwards he noticed a swelling over the hip, which increased in size and remained permanent. Six months later a similar swelling appeared over the left hip. A week

ago he had been sent to Dr. Coley with the diagnosis of sarcoma of the hip. On examination Dr. Coley found plain signs of spinal-cord trouble. The pupils responded to accommodation, but not to light; there was almost entire absence of the patellar reflexes, partial loss of sexual power, gastric crises, and such other evidences of locomotor ataxia as to make clear the diagnosis of Charcot's disease of the hip-joints. There was complete dislocation at both hips, and fracture at one, if not both. While standing the trochanters were four inches above the normal position, the joints were entirely disorganized, as shown by crepitus, and the hip could be placed in almost any position without causing pain. Crepitus was very plain in the right hip. Exostoses of considerable size were present on the left side, but originating from the ilium. The knees were not affected. The patient began to use a cane about eighteen months ago, and had gone on to use increasing support until at present it was difficult to get about with double crutches. He had attended to his practice until recently.

DR. BRIDDON remarked that, in this country at least, Charcot's disease of the hip-joint must be a rare condition, for only three cases had come under his own observation. The first was a case of Dr. Peters, at St. Luke's, fifteen or twenty years ago, before Charcot's disease had been recognized in America. The case gave rise to considerable discussion as to the diagnosis. The head of the femur was expanded, and permitted of easy displacement out of the acetabulum, but there were no exostoses on the pelvis.

He thought that in most cases the lesion involved the bone within the capsule of the joint. The bony projections were apt to seriously interfere with mobility.

DR. HOTCHKISS had seen one case of hip-joint trouble attending locomotor ataxia in a hospital patient, the chief cause of the pain and other joint symptoms being attributable to an enormous bursa over the greater trochanter. Only the one joint was affected.

DR. ABBE had seen a case of Dr. Weir's, in which the bony exostosis projected from the shaft of the femur above the knee.

DR. MEYER had seen three joints affected by Charcot's disease. In one case the knee was so badly involved that he consented to resect the joint. The patient was afterwards able to walk with a posterior splint, and lived many years. In one of the other cases a foot-joint was involved, and in the third a metacarpo-phalangeal joint.

DR. COLEY said, with regard to the frequency of the disease,

that Dr. Charcot had found it oftener than anybody else,—in 10 per cent. of cases of locomotor ataxia. Dr. Dana had found it in only 5 per cent. In many cases there was a history of syphilis, but this was absent in the present patient. It was an interesting fact that in this case the joint affection began late, ten years after the commencement of the cord-trouble, whereas in the majority of instances it showed itself in the incipient stage.

#### NEW URINAL FOR CONTINUOUS DRAINAGE AFTER SUPRAPUBIC CYSTOTOMY.

DR. WILLY MEYER presented a man, seventy-two years of age, to whose case he had referred about a month ago, when he presented a stone removed from his bladder by an incision above the symphysis pubis. There was also hypertrophy of the prostate for which he did not think any of the radical operations advisable, and therefore established permanent drainage.

Dr. Meyer had modified the urinal by placing in it a valve to prevent the urine from returning into the catheter when the patient assumed the horizontal posture. He had found by experience that the soft rubber plate over the abdominal opening fitted better than the one made of hard rubber and used by Dr. Bangs. A soft-rubber catheter extended from the bladder through the abdominal wall, the central perforation of the rubber plate was connected with the hard-rubber nozzle of the urinal, as the latter lay against the thigh. Bandages held the plate and urinal in position. The urinal was emptied by removing a screw at its bottom.

#### KELOTOMY WITH COCAINE ANÆSTHESIA.

DR. JOSEPH D. BRYANT presented a man, seventy-six years of age, who had entered St. Vincent's Hospital, in February, in substantially a state of collapse. The extremities were cold, the pulse very rapid and irregular. Fæcal vomiting, due to strangulated hernia, had existed for five days. Feeling that if ether were given it would be likely, under the circumstances, to cause speedy death, Dr. Bryant injected at once along the line of proposed incision thirty minims of a 2-per-cent. solution of cocaine. Then cutting freely down upon the protrusion, the intestine was returned, while the sac was simply tied, the entire time consumed having been only seven minutes and a half. The house surgeon was then directed to wash the stomach out thoroughly, in order to stop the fæcal vomiting, as this had in rare

cases persisted for some time after relieving the strangulated hernia, and in one or two cases had caused death.

Dr. Bryant said he presented the man simply to show what could be done with a weak solution of cocaine (2 per cent.), and with the stomach-tube in a case of strangulated hernia, which was ready to culminate in fatal collapse.

Dr. RUSHMORE thought that the age of the patient accounted in part for the small quantity of cocaine required to produce anæsthesia. Some time ago he had operated upon a man, aged eighty, who was almost in collapse with stercoraceous vomiting, due to strangulated hernia, and as he feared ether he used cocaine. The patient bore considerable cutting without complaint. Of course, the local anæsthetic effect of cocaine was well known, yet he thought considerable of the indifference to pain could be attributed to the patient's condition and to his great age.

Dr. WILLY MEYER then read the paper of the evening, on

#### RESECTION OF THE ABDOMINAL WALLS FOR NEO-PLASMS INVOLVING THE SAME.

Dr. BRIDDON said that some years ago he presented to the New York Pathological Society a tumor of the abdominal walls, about six or eight inches in diameter, apparently growing from the internal oblique, which the pathologist pronounced a myxofibroma. It was easily separated from the peritoneum. A hernia resulted into which all the intestines entered, and it was with difficulty that they were retained by bandage.

Dr. COLEY had seen three cases of sarcoma of the abdominal walls. The first was in 1888, in a young woman, on whom the operation suggested by Dr. Meyer was practised, and repeated three times for recurrence, the patient being lost sight of after the fourth operation. He had recently seen a case operated upon by Dr. Richardson, in Boston, August, 1893, the tumor extending to the left from the median line, and not involving the peritoneum. Dr. Richardson, having found the tumor too extensive for removal, referred the patient to Dr. Coley for treatment with the toxines of erysipelas, with the result that the tumor entirely disappeared under two and a half months treatment, and the patient fully recovered her health. The growth had been examined by Dr. Whitney, of the Harvard Medical School, and pronounced sarcoma. The patient was free from recurrence in May, 1894.

DR. BRYANT mentioned a case of sarcoma of the abdominal walls, operated upon by Dr. Phelps at St. Francis's Hospital, in which it was necessary to take away so much of the walls that it was not possible to make complete closure. The patient, however, made a prompt recovery. Any operation which made it necessary to take away a considerable portion of the parietes, or diminished their thickness over a considerable area, and rendered the patient liable to a very annoying hernia, was, he believed, regarded by surgeons generally with aversion, if not with dread. It was desirable, therefore, to bear in mind the fact that the omentum attached itself readily to all portions with which it was brought in contact, a fact which could be utilized by placing it in front of the intestine, and thus preventing this from adhering in an entangled condition to the seat of the wound.

#### SARCOMA OF THE KIDNEY.

DR. CHARLES MCBURNEY presented a sarcomatous kidney with the history of the case, of which the following is an abstract: T. B., aged ten years, admitted to Roosevelt Hospital April 10, 1894. Family history negative. Until present illness the patient was a strong, healthy boy. For five years had at times complained of scalding micturition. In June last he was struck with a base-ball just below the right costal border. He resumed his play, however. A short time afterwards he began to complain of attacks of severe pain in the right lumbar region, lasting but a few minutes at a time and recurring at intervals of about two weeks. About this time his mother noticed that he was losing flesh. In August he stooped a little to the right, the erect posture causing pain. The jolting during a long ride also caused him great pain. About the 1st of October his mother noticed that his abdomen was much distended. It caused no special distress, and physicians said it was due to gas. Two weeks later his mother noticed a mass below the right costal border, where he had been struck by the ball some months before. He then had an illness which confined him to bed for three weeks. It was characterized by much vomiting, severe pain in the right groin, and rapid wasting. November 12 a New York physician was consulted, and the diagnosis of sarcoma of the kidney was made. An operation was not suggested. He was then treated with plasters by a "cancer and tumors specialist." The tumor went on to increase greatly in size, especially during the last three weeks prior to admission. The pain became continuous, with severe exacerbations; vomiting about once a day; appetite

capricious; confined to house since past week. Nothing abnormal had been noticed about the urine, and it had been pronounced normal by those who examined it. The mother thought the amount was increased. Bowels costive.

On admission the boy was emaciated, cutaneous surface pale, abdomen prominent, being distended a little more on the right side than on the left. A rounded nodular mass was noticeable about the median line just below the umbilicus, about four inches in diameter. Umbilicus depressed; cutaneous veins dilated. Weight before illness was 75 pounds; on admission 67.5 pounds; circumference of chest under arms, 24 inches; at nipple line, 26; at level of eighth rib, 29; at umbilicus, 29.25; at anterior superior spinous process of ilium, 26.5 inches. The edge of the tumor could be felt as an irregular curved border approaching to within three inches of the anterior superior spinous process and the junction of the eighth with the seventh costal cartilage on the *left* side. The lumbar region bulged somewhat. In the right flank the mass felt tense, somewhat elastic, nodular, not moving with respiration. The smaller mass below the umbilicus could be moved with some freedom.

The patient had had no œdema, no characteristic pain of renal colic; urine found negative. Dr. McBurney operated April 14, incision in right lumbar region, beginning at the posterior axillary line and extending anteriorly four or five inches. Finding the tumor was not cystic, the incision was prolonged to the median line to a little below the umbilicus. A few adhesions existed between the surface of the tumor and the abdominal parietes, while to the colon and mesentery the tumor was strongly adherent, and in its separation a little sarcomatous tissue had to be left on the gut. The boy's condition did not permit of intestinal resection. The pedicle was brought into view, the renal vein and artery and the smaller vessels were seized by clamps and the tumor was removed. The previously-arranged plan of operation had included intravenous saline infusion, and during the operation 800 cubic centimetres of hot salt solution were injected into the median basilic vein.

The improvement in the condition of the pulse was rapid and striking, and led Dr. McBurney to again emphasize the importance of being prepared to make infusion in operations of a major character or upon patients in low condition. Iodoform gauze packing was introduced about the clamps. The anterior half of the wound was closed with catgut in layers, the clamps and packing occupying the

posterior half. Hæmorrhage during the operation was slight, and the pulse at its close was very satisfactory. The colon from which mesentery had been torn was drawn so as to present its surface to the packing. The tumor was globular in shape, with a distinct capsule, surface smooth and even, except for two hemispherical projections which were softer than the remainder of the tumor. From the lower end there projected a pedunculated mass, 4 by 3 by 2 inches, with a pedicle 2.5 by 1.5 inches. This was of denser consistency than the rest of the tumor, and it was to this that the colon had been attached. On cross section the tumor was soft, friable, and apparently sarcomatous. At the upper and back part of the tumor was the easily recognized kidney which apparently merged at its lower part into the tumor. The dimensions of the tumor were: vertical circumference at one part 25.5, at another 27 inches; horizontal circumference, 23.5 inches; weight, 9.75 pounds. The pathologist, Dr. Hodenpyl, had reported that the section of the small portion of kidney tissue at the upper end was normal. There was a sharp line of demarcation between the kidney and the tumor at the point of junction. The latter was a myo-chondro-adenocarcinoma.

The patient had made a good recovery from the operation, and the wound was now small and granulating in a healthy manner. Recurrence at a not distant date is to be expected.

In commenting upon the case, Dr. McBurney said the only great difficulty encountered during the operation depended upon the adhesion of the intestine to a portion of the growth which could not have existed more than a month, showing that, had the physician recommended an operation as soon as a diagnosis was made, the tumor could have been removed much more readily and with less danger to life. The packing was partially removed at the end of the second day, and at the same time all the clamps were taken away. Very slight bleeding from one small vessel occurred which was easily controlled by renewed packing. Complete change of packing was made on the sixth day, on the eleventh day two very small fæcal fistulæ formed. The discharges have been entirely controlled by packing.

DR. MCBURNEY added, with regard to the use of clamps, that there were several reasons for employing them in preference to ligatures. They saved time, the ligature might cut through the walls of the large thin vessels, especially of the renal vein, which would necessitate the loss of further time in again securing it; the ligature might break, especially if tied eagerly and rapidly. Another point of value

in this case, and which would be likely to prove very important in similar cases, was the use of intravenous saline infusion, for which preparation had been made before beginning the operation. The infusion was not made because the patient had lost blood, but because he was expected to lose blood, especially the amount contained in the tumor itself which was to be removed. It did not involve loss of time, as the infusion was made by one of the assistants while the operation was going on. He had no doubt but what this precaution saved the patient's life, or that without it the patient would have died.

DR. ABBE thought that some points in the technique of the operation were worthy of special mention. The saving of time by leaving clamps on the vessels instead of ligating them added not a little to the patient's chances of recovery. He also thought Trendelenburg's posture would be found of great value in such cases, as he had used it in three cases of large renal tumors. The two patients shown by himself a few months ago had continued in perfect health. In one he had removed the kidney for sarcoma nearly two years and a half ago, in the other about sixteen months ago. He had operated in a third case four weeks ago, removing a sarcomatous kidney, weighing a pound and a half, without difficulty and with the loss of not more than an ounce of blood. A fourth patient had come under his notice recently, and although the parents had given their consent to an operation, they refused it at the last moment, and took the child home after it had been in the hospital only twenty-four hours. It died within four weeks. The tumor would have weighed twelve or fifteen pounds. Those who made the autopsy said it could have been removed successfully.

#### RETAINED GALL-STONES WITH CONTRACTED GALL-BLADDER.

DR. ABBE presented some gall-stones which he had recently removed from a woman who had suffered more than five years from attacks of biliary colic. A short time ago two physicians had cut down upon the gall-bladder, had palpated it, and, feeling no stones, had closed the wound without entering the gall-bladder. When Dr. Abbe saw the patient, he was convinced that it was a case of gall-stones, although he was unable to palpate them even after exposing the gall-bladder. On cutting into the atrophied viscus seven small stones were found and removed. He had before had several cases in which small stones could not be felt through the walls of the exposed viscus.